

BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

DEEPAK K. SANAN, M.D.

Holder of License No. 24212
For the Practice of Allopathic Medicine
In the State of Arizona

Case No. MD-05-0625A

**CONSENT AGREEMENT FOR
LETTER OF REPRIMAND**

CONSENT AGREEMENT

By mutual agreement and understanding, between the Arizona Medical Board ("Board") and Deepak K. Sanan, M.D. ("Respondent"), the parties agreed to the following disposition of this matter.

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order ("Consent Agreement"). Respondent acknowledges that he has the right to consult with legal counsel regarding this matter.

2. By entering into this Consent Agreement, Respondent voluntarily relinquishes any rights to a hearing or judicial review in state or federal court on the matters alleged, or to challenge this Consent Agreement in its entirety as issued by the Board, and waives any other cause of action related thereto or arising from said Consent Agreement.

3. This Consent Agreement is not effective until approved by the Board and signed by its Executive Director.

4. The Board may adopt this Consent Agreement of any part thereof. This Consent Agreement, or any part thereof, may be considered in any future disciplinary action against Respondent.

5. This Consent Agreement does not constitute a dismissal or resolution of other matters currently pending before the Board, if any, and does not constitute any waiver,

1 express or implied, of the Board's statutory authority or jurisdiction regarding any other
2 pending or future investigation, action or proceeding. The acceptance of this Consent
3 Agreement does not preclude any other agency, subdivision or officer of this State from
4 instituting other civil or criminal proceedings with respect to the conduct that is the subject
5 of this Consent Agreement.

6 6. All admissions made by Respondent are solely for final disposition of this
7 matter and any subsequent related administrative proceedings or civil litigation involving
8 the Board and Respondent. Therefore, said admissions by Respondent are not intended
9 or made for any other use, such as in the context of another state or federal government
10 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or
11 any other state or federal court.

12 7. Upon signing this agreement, and returning this document (or a copy thereof) to
13 the Board's Executive Director, Respondent may not revoke the acceptance of the
14 Consent Agreement. Respondent may not make any modifications to the document. Any
15 modifications to this original document are ineffective and void unless mutually approved
16 by the parties.

17 8. If the Board does not adopt this Consent Agreement, Respondent will not
18 assert as a defense that the Board's consideration of this Consent Agreement constitutes
19 bias, prejudice, prejudgment or other similar defense.

20 9. This Consent Agreement, once approved and signed, is a public record that will
21 be publicly disseminated as a formal action of the Board and will be reported to the
22 National Practitioner Data Bank and to the Arizona Medical Board's website.

23 10. If any part of the Consent Agreement is later declared void or otherwise
24 unenforceable, the remainder of the Consent Agreement in its entirety shall remain in force
25 and effect.

1 11. Any violation of this Consent Agreement constitutes unprofessional conduct
2 and may result in disciplinary action. A.R.S. § § 32-1401(27)(r) ("[v]iolating a formal order,
3 probation, consent agreement or stipulation issued or entered into by the board or its
4 executive director under this chapter") and 32-1451.

5
6
7 Deepak K. Sanan
8 DEEPAK K. SANAN, M.D.

DATED: 10-26-06

1 **FINDINGS OF FACT**

2 1. The Board is the duly constituted authority for the regulation and control of
3 the practice of allopathic medicine in the State of Arizona.

4 2. Respondent is the holder of license number 24212 for the practice of
5 allopathic medicine in the State of Arizona.

6 3. The Board initiated case number MD-05-0625A after receiving notification of
7 a malpractice settlement involving Respondent's care and treatment of a twenty-eight
8 year-old female patient ("SJ").

9 4. On August 14, 1997 SJ presented to Respondent, an endocrinologist, for a
10 thyroid evaluation. SJ had a history of Hodgkin's disease at age fourteen that was treated
11 with surgery, splenectomy and X-ray therapy (mantle radiation). Respondent examined SJ
12 and noted an enlarged thyroid gland, approximately twice the normal size, with the right
13 lobe being larger than the left. Respondent increased SJ's thyroid hormone dose and saw
14 her for follow-up visits on October 2, 1997, November 24, 1997, January 12, 1998, April
15 17, 1998, and August 24, 1998. Respondent noted at each follow-up visit SJ's thyroid
16 gland remained unchanged by noting "goiter" in the record. Respondent did not document
17 whether the enlarged thyroid could be a result of a nodule or mass. Respondent ordered
18 repeat lab work to assess thyroid function and adjusted SJ's thyroid medication in
19 response to the lab results. There is no indication in the record that Respondent ordered
20 an ultrasound to further evaluate SJ's thyroid gland or whether he considered SJ's
21 previous treatment for Hodgkin's disease put her at greater risk for thyroid cancer.

22 5. On December 1, 1998, over one year after noting SJ's enlarged thyroid
23 gland, Respondent consulted with another endocrinologist ("Physician"). Physician
24 recommended a thyroid ultrasound to check size and nodularity of the thyroid gland. SJ
25 underwent the ultrasound examination on December 7, 1998 and it revealed a large right-

1 sided thyroid mass, 5cm in its largest dimension and a normal left thyroid lobe. The
2 records do not show that Respondent saw SJ after she had the ultrasound or that
3 Respondent arranged for a nodule biopsy.

4 6. On January 1, 1999 SJ's treating oncologist ("Oncologist") performed a fine
5 needle aspiration of SJ's right thyroid nodule revealing an atypical hypercellular follicular
6 lesion with trabecular and microfollicular pattern. Oncologist scheduled an excision
7 procedure on May 24, 1999 to rule out possible thyroid malignancy. On May 24, 1999
8 Oncologist performed a total thyroidectomy. An intra-operative frozen section revealed
9 trabecular neoplasm. A final pathology revealed insular carcinoma, which arose within a
10 microfollicular adenoma. Post-operatively SJ did well and underwent two subsequent
11 radioactive iodine therapies on February 7, 2000 and April 7, 2000.

12 7. In October 2000 Oncologist diagnosed SJ with bilateral pulmonary
13 metastases. She was administered another iodine therapy in April 2001, but her cancer
14 was no longer iodine responsive. The cancer spread to SJ's brain, liver, kidney, gluteal
15 muscles and bones.

16 8. On April 15, 2003 SJ died.

17 9. A physician is required to maintain adequate legible medical records
18 containing, at a minimum, sufficient information to identify the patient, support the
19 diagnosis, justify the treatment, accurately document the results, indicate advice and
20 cautionary warnings provided to the patient and provide sufficient information for another
21 practitioner to assume continuity of the patient's care at any point in the course of
22 treatment. A.R.S. § 32-1401(2). Respondent's records were inadequate because he did
23 not note he ordered an ultrasound to further evaluate SJ's thyroid gland, that the
24 enlargement of the right side of the thyroid he referred to as a goiter might have been due
25

1 to a nodule or mass, and whether he considered SJ's previous treatment for Hodgkin's
2 disease put her at a significantly greater risk of thyroid cancer.

3 10. The standard of care for a patient with a history of being treated with mantle
4 radiation therapy for Hodgkin's disease who presents with an enlarged lobe of the thyroid
5 gland required Respondent to either image the gland or immediately perform a fine needle
6 aspiration biopsy to rule out malignancy.

7 11. Respondent deviated from the standard of care because he did not order an
8 ultrasound or perform a fine needle aspiration for over one year after noting an abnormal
9 thyroid gland.

10 12. Respondent's delay in assessing SJ's abnormal thyroid gland led to a delay
11 in diagnosis and treatment of thyroid cancer and may have reduced SJ's chances of a
12 better outcome.

13 CONCLUSIONS OF LAW

14 1. The Board possesses jurisdiction over the subject matter hereof and over
15 Respondent.

16 2. The conduct and circumstances described above constitute unprofessional
17 conduct pursuant to A.R.S. § 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate
18 records on a patient.").

19 3. The conduct and circumstances described above constitute unprofessional
20 conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be
21 harmful or dangerous to the health of the patient or the public.").

22 4. The conduct and circumstances described above constitute unprofessional
23 conduct pursuant to A.R.S. § 32-1401 (27)(II) ("[c]onduct that the board determines is
24 gross negligence, repeated negligence or negligence resulting in harm to or the death of a
25 patient.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand for failing to appropriately assess an asymmetric thyroid gland in a patient with a history of radiation therapy to the gland and for inadequate medical records.

2. This Order is the final disposition of case number MD-05-0625A.

DATED AND EFFECTIVE this 7th day of December, 2006.

(SEAL)



ARIZONA MEDICAL BOARD

By

Timothy C. Miller

TIMOTHY C. MILLER, J.D.

Executive Director

ORIGINAL of the foregoing filed
this 8th day of December, 2006 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

EXECUTED COPY of the foregoing mailed
this 8th day of December, 2006 to:

Deepak K. Sanan, M.D.
Address of Record

Jim McGraw

Investigational Review